Office of Vermont Health Access
DENTAL PROCEDURE/FEE SCHEDULE

Effective for services provided on or after 01/01/08

Legend:

Adult Program:

Y = Procedure is a covered service for the Adult Program.
The Adult Program is limited to **$495** per individual per calendar year.
N = Procedure is not a covered service for the Adult Program.

If an individual reaches their 21st birthday and has received dental care during the course of the year, the dental benefit already paid will be applied to the annual $495 adult maximum benefit. The benefit is considered exhausted if the total reimbursement is greater than or equal to $495 and will not begin again until the start of the new calendar year.

Authorization Status (A):

0 = No prior authorization required.
1 = Prior authorization required by The Office of Oral Health. If appropriate, please forward radiographs for review.

By Report: When a procedure is followed by this statement, please provide a brief description of the service and forward the claim to The Office of Oral Health for review.

FEE: ** = Individual Consideration.

Co-Payment:

Adults are responsible for a co-payment for all dental services. The co-payment amount is $3/adult/provider/date of service. EDS will automatically deduct the co-payment from the amount paid to the provider.

Exceptions to Co-Payments:

1. An individual residing in a participating long-term care facility (nursing home). EDS has this information on file and will not deduct the co-payment from the amount paid to the provider.
2. An individual who is pregnant or in the 60-day post pregnancy period. EDS does not have this information on file. When submitting claim forms to EDS for payment, you must indicate pregnancy and 60-day post pregnancy by adding the "HD" modifier to the end of each procedure code. The "HD" modifier must be used for all procedures. For example, when submitting for a periodic oral evaluation, use procedure code D0120HD.
3. An individual who is under 21 years of age and considered a child by The Office of Vermont Health Access.

Procedures Requiring Prior Authorization:

Submit requests to: Office of Oral Health
Vermont Department of Health
108 Cherry Street
Drawer #28
Post Office Box 70
Burlington, VT 05402
(802) 863-7341 or (800) 464-4343, extension 7341

Please contact The Office of Oral Health for consideration of unusual or extenuating circumstances, including procedures with date restrictions.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM

I. DIAGNOSTIC:

A. Clinical Oral Evaluations: The codes in this section recognize the cognitive skills necessary for patient evaluation. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, diagnosis and treatment planning are the responsibility of the dentist. As with all procedure codes, there is no distinction made between the evaluations provided by general practitioners and specialists. Report additional diagnostic and/or definitive procedures separately.

D0120	Periodic Oral Evaluation An evaluation performed on a patient to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures.	18	0	Y

► Periodic oral evaluations are limited to 1 per patient per 180 days. If more frequent periodic oral evaluations are required, use the attached Dental Services Prior Authorization Request Form to submit a prior authorization request to The Office of Oral Health documenting the need for the additional periodic oral evaluation.

D0140	Limited Oral Evaluation – Problem Focused An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Definitive procedures may be required on the same day as this evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.	30	0	Y♦

► Limited oral evaluations are limited to 1 per patient per provider per date of service.

D0145	Oral Evaluation for a patient under three years of age and counseling with primary caregiver Diagnostic and preventive services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver.	39	0	N

► Procedure code D0145 is limited to children 2 years old and younger.

► The reimbursement for procedure code D0145 includes all anticipatory guidance provided to the family, including oral hygiene instructions. Note that you cannot bill for oral hygiene instructions (procedure code D1330) on the same date of service as procedure code D0145.

► Procedure code D0145 is limited to 1 per patient per 180 days. If more frequent oral evaluations are required, use the attached Dental Services Prior Authorization Request Form to submit a prior authorization request to The Office of Oral Health documenting the need for the additional oral evaluation.

♦ This procedure is not subject to the Adult Program $495 annual maximum benefit.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM
A.	**Clinical Oral Evaluations - continued:**			
D0150	Comprehensive Oral Evaluation An evaluation used by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, by report, or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. This includes an evaluation for oral cancer where indicated, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.	32	0	Y

► Comprehensive oral evaluations are limited to 1 per patient per provider per 3 years. If a comprehensive oral evaluation is required earlier than the 3-year limit, use the attached Dental Services Prior Authorization Request Form to submit a prior authorization request to The Office of Oral Health documenting the need for the additional comprehensive oral evaluation.

D0170	Re-evaluation – Limited, Problem Focused Assessing the status of a previously existing condition. For example: - a traumatic injury where no treatment was rendered but patient needs follow-up monitoring; - evaluation for undiagnosed continuing pain; - soft tissue lesion requiring follow-up evaluation. This code is NOT to be used for a post-operative visit.	30	0	Y♦

► Re-evaluations are limited to 1 per patient per provider per date of service.

B.	**Radiographs:**			
D0210	Intraoral – Complete Series (including bitewings)	56	0	Y

► A complete series of radiographs and/or a panoramic radiograph is limited to 1 per patient per 2 years. If a complete series of radiographs is required earlier than the 2-year limit, use the attached Dental Services Prior Authorization Request Form to submit a prior authorization request to The Office of Oral Health documenting the need for the additional complete series of radiographs.

D0220	Intraoral – Periapical – First Film	17	0	Y
D0230	Intraoral – Periapical – Each Additional Film	7	0	Y

► Intraoral periapicals are limited to 7 per date of service. If more than 7 radiographs are required, submit as a complete series.

♦ This procedure is not subject to the Adult Program $495 annual maximum benefit.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM
	B. Radiographs – continued:			
D0240	Intraoral – Occlusal Film	16	0	Y
D0250	Extraoral – First Film	33	0	Y
D0260	Extraoral – Each Additional Film	17	0	Y
D0270	Bitewing – Single Film	11	0	Y
D0272	Bitewings – 2 Films	17	0	Y
D0273	Bitewings – 3 Films	21	0	Y
D0274	Bitewings – 4 Films	25	0	Y

► Bitewing radiographs are limited to 1 set per 180 days. If more frequent bitewing radiographs are required, use the attached Dental Services Prior Authorization Request Form to submit a prior authorization request to The Office of Oral Health documenting the need for the additional bitewing radiographs.

D0330	Panoramic Film	48	0	Y

► A panoramic radiograph and/or a complete series of radiographs are limited to 1 per patient per 2 years. If a panoramic radiograph is required earlier than the 2-year limit, use the attached Dental Services Prior Authorization Request Form to submit a prior authorization request to The Office of Oral Health documenting the need for the additional panoramic radiograph.

D0340	Cephalometric Film	56	0	N

► Cephalometric radiographs are limited to 1 per patient per 2 years.

D0350	Oral/Facial Photographic Images This includes photographic images, including those obtained by intraoral and extraoral cameras, excluding radiographic images. These photographic images should be part of the patient's clinic record.	28	0	N

► Oral/Facial Photographic Images are limited to once per patient per 2 years.

	C. Other Diagnostic Procedures:			
D0470	Diagnostic Models	41	0	Y

► Diagnostic models are limited to 1 set per patient per 2 years.

D0999	Missed Appointment or Late Cancellation Reporting Code	00	0	Y

► This code is used to report missed appointments and late cancellations to The OVHA. This code is used for reporting purposes only and there is NOT a reimbursement associated with the billing of this code.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM
II.	**PREVENTIVE TREATMENT:**			
A.	**Prophylaxis:**			
D1110	Prophylaxis – Adult Removal of plaque, calculus and stains from the tooth structures in the permanent (adult) and transitional dentition. It is intended to control local irritational factors.	39	0	Y
D1120	Prophylaxis – Child Removal of plaque, calculus and stains from the tooth structures in the primary (deciduous) and transitional dentition. It is intended to control local irritational factors.	29	0	N

Definitions:

Primary (Deciduous) Dentition: Teeth developed and erupted first in order of time.

Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

Permanent (Adult) Dentition: The dentition that is present after the cessation of growth.

► Prophylaxis is limited to 1 per patient per 180 days. If more frequent prophylaxis is required, use the attached Dental Services Prior Authorization Request Form to submit a prior authorization request to The Office of Oral Health documenting the need for the additional prophylaxis.

B.	**Topical Fluoride Treatment:** Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste.			
D1203	Topical Application of Fluoride – Child Limited to children 20 years and younger.	15	0	N
D1204	Topical Application of Fluoride – Adult Limited to adults 21 years and older.	15	0	Y

► Topical fluoride treatments are limited to 1 treatment per patient per 180 days. If more frequent fluoride treatments are required, use the attached Dental Services Prior Authorization Request Form to submit a prior authorization request to The Office of Oral Health documenting the need for the additional fluoride treatment.

D1206	Topical Fluoride Varnish; Therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	15	0	Y

► Fluoride varnish applications are limited to 1 application per patient per 180 days. If more frequent fluoride varnish applications are required, use the attached Dental Services Prior Authorization Request Form to submit a prior authorization request to The Office of Oral Health documenting the need for the additional fluoride treatment.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM
C.	**Other Preventive Services:**			
D1330	Oral Hygiene Instructions	21	0	N

► Oral hygiene instructions are limited to children 4 years old and younger.

► Oral hygiene instructions are limited to 1 time per patient per year. If more frequent oral hygiene instructions are required, use the attached Dental Services Prior Authorization Request Form to submit a prior authorization request to The Office of Oral Health documenting the need for the additional instructions.

D1351	Sealant – Per Tooth* Limited to permanent first and second molars.	28	0	N
D1351U9	Sealant – Per Tooth-Deciduous second molars and bicuspids* When submitting claims for the placement of sealants on deciduous second molars and bicuspids you must add the "U9" modifier to the end of procedure code D1351. For example, when submitting for a sealant placed on tooth #28, use procedure code D1351U9.	8	0	N

* Once a sealant is placed, the provider is responsible for the maintenance of that sealant for a period of 5 years.

► Sealants are limited to 1 per tooth per 5 years.

► The surfaces eligible for sealants are limited to Occlusal (O), Buccal (B), Occlusal-Buccal (OB) and Occlusal-Lingual (OL).

D.	**Space Maintenance:**			
D1510	Space Maintainer - Fixed – Unilateral	145	0	N
D1515	Space Maintainer – Fixed – Bilateral	204	0	N
D1525	Space Maintainer – Removable – Bilateral	195	0	N
D1550	Recementation of Space Maintainer	34	0	N

► When submitting for payment for space maintainers, indicate a corresponding tooth number on the completed claim form.

► Space maintainers are limited to 1 identical space maintainer per patient per 2 years.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM

III. RESTORATIVE: (Local anesthesia is considered to be a component of all restorative procedures.)

A. Amalgam Restorations: Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951).

D2140	Amalgam – One Surface, Primary or Permanent	66	0	Y
D2150	Amalgam – Two Surfaces, Primary or Permanent	73	0	Y
D2160	Amalgam – Three Surfaces, Primary or Permanent	89	0	Y
D2161	Amalgam – Four or more Surfaces, Primary or Permanent	109	0	Y

► Amalgam restorations are limited to 1 identical restoration per tooth per year.

B. Resin-Based Restorations: Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, etching, adhesives (including resin bonding agents), liners and bases and curing are included as part of the restoration. Glass ionomers, when used as restorations should be reported with these codes. If pins are used, they should be reported separately (see D2951).

D2330	Resin-Based Composite – One Surface, Anterior	80	0	Y
D2331	Resin-Based Composite – Two Surfaces, Anterior	99	0	Y
D2332	Resin-Based Composite – Three Surfaces, Anterior	116	0	Y
D2335	Resin – Four or more Surfaces or involving incisal angle, Anterior	133	0	Y
D2390	Resin-Based Composite crown, Anterior	225	0	Y
D2391	Resin-Based Composite – One Surface, Posterior	90	0	Y
D2392	Resin-Based Composite – Two Surfaces, Posterior	133	0	Y
D2393	Resin-Based Composite – Three Surfaces, Posterior	179	0	Y
D2394	Resin-Based Composite – Four or more Surfaces, Posterior	189	0	Y

► Resin-Based restorations are limited to 1 identical restoration per tooth per year.

C. Cast Crowns:

D2720	Crown – Resin to High Noble Metal	456	0	N
D2740	Crown – Porcelain/Ceramic	470	0	N
D2750	Crown – Porcelain to High Noble	465	0	N
D2751	Crown – Porcelain to Base Metal	420	0	N
D2752	Crown – Porcelain to Noble Metal	449	0	N
D2790	Crown – Full Cast High Noble Metal	457	0	N
D2791	Crown – Full Cast Base Metal	407	0	N
D2792	Crown – Full Cast Noble Metal	446	0	N
D2920	Recement Crown	42	0	Y

► Cast Crowns are limited to 1 per tooth per 2 years.

► When submitting for payment for cast crowns, use the start date (final impression date) as the date of service on the completed claim. Do not submit the claim until the cast crown is delivered.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM
D.	**Prefabricated Crowns:**			
D2930	Stainless Steel Crown – Primary	160	0	Y
D2931	Stainless Steel Crown – Permanent	144	0	Y
D2932	Prefabricated Resin Crown	136	0	Y
D2933	Prefabricated Stainless Steel Crown with Resin Window	123	0	Y
► Prefabricated crowns are limited to 1 per tooth per 2 years.				
E.	**Other Restorative Procedures:**			
D2940	Sedative Filling Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.	43	0	Y
► When submitting for a sedative filling, indicate the corresponding tooth number and tooth surfaces on the completed claim form.				
D2950	Core Build-up – Including Pins Core build-up refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure.	115	0	Y
D2951	Pin Retention, Per Tooth	39	0	Y
► Pin retention is limited to once per tooth per year.				
D2952	Post and Core in addition to crown, indirectly fabricated Post and core are custom fabricated as a single unit.	307	0	N
D2954	Prefabricated Post and Core Core is built around a prefabricated post. This procedure includes the core material.	141	0	Y
D2960	Labial Veneer – Laminate	220	0	N
D2980	Crown Repair, by report	110	1	N
D2999	Unspecified Restorative Procedure, by report	**	1	N

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM
IV.	**ENDODONTICS:** (Local anesthesia is considered to be a component of all endodontic procedures.)			
A.	**Pulpotomy:**			
D3220	Therapeutic Pulpotomy (Excluding final restoration) Removal of pulp coronal to the dentinocemental junction and application of medicament. Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. - To be performed on primary or permanent teeth. - This is not to be construed as the first stage of root canal therapy.	75	0	Y
D3221	Pulpal Debridement, primary and permanent teeth Pulpal debridement for the relief of acute pain prior to conventional root canal therapy. This procedure is not to be used when endodontic treatment is completed on the same day.	50	0	Y
► Pulpotomy and Pulpal Therapy limited to 1 per tooth per lifetime.				
B.	**Endodontic Therapy for Primary Teeth:**			
D3230	Pulpal Therapy (resorbable filling) Anterior Primary Tooth	100	0	Y
D3240	Pulpal Therapy (resorbable filling) Posterior Primary Tooth	125	0	Y
C.	**Endodontic Therapy:**			
D3310	Anterior (Excluding Final Restoration)	284	0	Y
D3320	Bicuspid (Excluding Final Restoration)	341	0	Y
D3330	Molar (Excluding Final Restoration)	430	0	Y

► Endodontic therapy for the Adult Program is limited to 3 teeth per patient per adult lifetime.

► When submitting for payment for completed endodontic therapy, use the start date as the date of service on the completed claim. Do not submit the claim until endodontic treatment is completed.

► Regardless of the funding source for the initial endodontic procedure, endodontic retreatment is not a covered service.

D.	**Apexification/Recalcification Procedures:**			
D3351	Apexification/Recalcification – Initial Visit	284	0	N
D3352	Apexification/Recalcification – Interim Medication Placement	300	0	N
D3353	Apexification/Recalcification – Final Visit	169	0	N

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM
E.	**Apicoectomy/Periradicular Surgery:**			
D3410	Apicoectomy/Periradicular Surgery Anterior	260	0	Y
D3421	Apicoectomy/Periradicular Surgery Bicuspid (First Root)	297	0	Y
D3425	Apicoectomy/Periradicular Surgery Molar (First Root)	338	0	Y
D3426	Apicoectomy/Periradicular Surgery Each Additional Root	170	0	Y
D3430	Retrograde Filling – Per Root	99	0	Y
► Apicoectomy procedures are limited to 1 per tooth per lifetime.				
D3450	Root Amputation – Per Root	181	0	N
F.	**Other Endodontic Procedures:**			
D3910	Surgical Procedure for Isolation of Tooth With Rubber Dam	71	0	N
D3920	Hemisection (Including any Root Removal. Not Including Root Canal Therapy)	181	0	N
D3999	Unspecified Endodontic Procedure, by report	**	1	N

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM

V. **PERIODONTICS:** (Local anesthesia is considered to be a component of all periodontal procedures.)

A. Surgical Services:

D4210	Gingivectomy or Gingivoplasty, Four or more contiguous teeth or bounded teeth spaces per quadrant	273	0	N
D4211	Gingivectomy or Gingivoplasty, One to three contiguous teeth or bounded teeth spaces, per quadrant	84	0	N
D4240	Gingival Flap Procedure, Including Root Planing – Four or more contiguous teeth or bounded teeth spaces per quadrant	308	0	N
D4241	Gingival Flap Procedure, Including Root Planing – One to three contiguous teeth or bounded teeth spaces, per quadrant	150	0	N
D4249	Clinical Crown Lengthening-Hard Tissue This procedure is employed to allow restorative procedure or crown with little or no tooth structure exposed to the oral cavity. Requires reflection of a flap and is performed in a healthy periodontal environment.	250	0	N
D4260	Osseous Surgery (including flap entry and closure) – Four or more contiguous teeth or bounded teeth spaces, per quadrant	449	0	N
D4261	Osseous Surgery (including flap entry and closure) – One to three contiguous teeth or bounded teeth spaces, per quadrant	200	0	N
D4270	Pedicle Soft Tissue Graft Procedure	338	0	N
D4271	Free Soft Tissue Graft Procedure Including Donor Site Surgery	373	0	N

► Periodontal surgery is limited to 4 procedures per patient per lifetime.

B. Adjunctive Periodontal Services:

D4320	Provisional Splinting – Intracoronal	185	0	Y
D4321	Provisional Splinting – Extracoronal	161	0	Y
D4341	Periodontal Scaling and Root Planing Four or more contiguous teeth per Quadrant	84	0	Y
D4342	Periodontal Scaling and Root Planing One to three teeth, per Quadrant	25	0	Y

► Periodontal scaling and root planing is limited to 4 quadrants per patient per year. If more frequent scaling and root planing is required, use the attached Dental Services Prior Authorization Request Form to submit a prior authorization request to The Office of Oral Health documenting the need for the additional scaling and root planing.

D4355	Full Mouth Debridement to Enable Comprehensive Periodontal Evaluation and Diagnosis. The gross removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation.	72	0	Y

► Full mouth debridement is limited to 1 per patient per 2 years. If more frequent full mouth debridements are required, use the attached Dental Services Prior Authorization Request Form to submit a prior authorization request to The Office of Oral Health documenting the need for the additional full mouth debridement.

► A prophylaxis cannot be completed on the same date of service as a full mouth debridement.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM
C.	**Other Periodontal Services:**			
D4910	Periodontal Maintenance This procedure is instituted following periodontal therapy and continues at varying levels, determined by the clinical evaluation by the dentist. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and polishing the teeth. This procedure is performed rather than a prophylaxis for patients following periodontal therapy.	59	0	Y

► Periodontal maintenance procedures are limited to 1 per patient per 180 days. If more frequent periodontal maintenance procedures are required, use the attached Dental Services Prior Authorization Request Form to submit a prior authorization request to The Office of Oral Health documenting the need for the additional procedure.

D4999	Unspecified Periodontal Procedure, by report	**	1	N

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM

VI. **REMOVABLE PROSTHODONTICS:**
(Local anesthesia is considered to be a component of all removable prosthodontic procedures.)

A. Complete Dentures, Immediate Dentures and Overdentures:

D5110	Complete Denture – Maxillary	605	1	N♣
D5120	Complete Denture – Mandibular	605	1	N♣

► A complete lower denture will **not** be prior authorized when it will oppose upper natural teeth.

D5130	Immediate Denture – Maxillary	626	1	N♣
D5140	Immediate Denture – Mandibular	626	1	N♣

► Immediate dentures are limited to 1 per arch per lifetime.
► Following the delivery of an immediate denture, a complete denture cannot be prior authorized for a minimum of 5 years.
► An immediate denture will be prior authorized if 6 or fewer anterior teeth only are remaining in the arch.

D5860	Overdenture – Complete	600	1	N♣

► An overdenture will be prior authorized only if 2 or fewer teeth are remaining in the arch.

B. Partial Dentures:

D5211	Maxillary Partial Denture – Resin Base*	413	1	N♣
D5212	Mandibular Partial Denture – Resin Base*	413	1	N♣
D5213	Maxillary Partial Denture – Cast Framework*	638	1	N♣
D5214	Mandibular Partial Denture – Cast Framework*	638	1	N♣

* Including Any Conventional Clasps and Rests.

♣ To prior authorize denture (s) submit a completed "Denture Prior Authorization Request Form" to The Office of Oral Health. A current "Denture Prior Authorization Request Form" is attached to this fee schedule.

♣ When submitting for payment of prior authorized denture(s), use the start date (final impression date) as the date of service on the completed claim form. Do not submit the claim until the denture(s) are delivered.

♣ Reimbursement includes all necessary post delivery denture adjustments for 3 months.

♣ Regardless of the funding source, dentures are limited to 1 per arch per 5 years. However, replacement denture (s) will be considered in less than 5 years in the following circumstances:
a. The previous denture (s) have been stolen or destroyed in an accident **and** a police report has been filed.
b. The previous denture (s) have been destroyed in a fire **and** a fire report has been filed.
c. There are other equally compelling circumstances beyond the recipient's control.

♣ Dentures will **not** be prior authorized if existing dentures are serviceable.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM
C.	**Denture Adjustments:**			
D5410	Adjust Complete Denture – Maxillary	36	0	Y
D5411	Adjust Complete Denture – Mandibular	36	0	Y
D5421	Adjust Partial Denture – Maxillary	36	0	Y
D5422	Adjust Partial Denture – Mandibular	36	0	Y

► Denture adjustments are limited to 1 per denture per 180 days.

D.	**Denture Repairs:**			
D5510	Repair Broken Complete Denture Base	77	0	N
D5520	Repair Missing or Broken Teeth – Complete Denture	74	0	N
D5610	Repair Resin Denture Base – Partial	76	0	N
D5620	Repair Cast Framework – Partial	117	0	N
D5630	Repair or Replace Broken Clasp – Partial Denture	105	0	N
D5640	Replace Broken Teeth on Existing Partial – Per Tooth	72	0	N
D5650	Add Tooth to Existing Partial Denture	88	0	N
D5660	Add Clasp to Existing Partial Denture	116	0	N

► Denture repairs are limited to one per denture per 180 days.

E.	**Denture Rebases:**			
D5710	Rebase Complete Maxillary Denture (Laboratory)	223	1	N
D5711	Rebase Complete Mandibular Denture (Laboratory)	223	1	N
D5720	Rebase Maxillary Partial Denture (Laboratory)	221	1	N
D5721	Rebase Mandibular Partial Denture (Laboratory)	221	1	N

► Denture rebases and/or relines are limited to 1 per denture per 2 years.

► To prior authorize denture rebase (s) submit a completed "Denture Prior Authorization Request Form" to The Office of Oral Health.

F.	**Denture Relines:**			
D5750	Reline Complete Maxillary Denture (Laboratory)	201	1	N
D5751	Reline Complete Mandibular Denture (Laboratory)	201	1	N
D5760	Reline Maxillary Partial Denture (Laboratory)	198	1	N
D5761	Reline Mandibular Partial Denture (Laboratory)	198	1	N

► Denture relines and/or rebases are limited to 1 per denture per 2 years.

► To prior authorize denture reline (s) submit a completed "Denture Prior Authorization Request Form" to The Office of Oral Health.

G.	**Other Removable Prosthetic Services:**			
D5850	Tissue Conditioning – Maxillary	72	0	Y
D5851	Tissue Conditioning – Mandibular	72	0	Y
D5899	Unspecified Removable Prosthodontic Procedure, by report	**	1	N

► Tissue Conditioning is limited to 1 per denture per 2 years.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM

VII. **FIXED PROSTHODONTICS:**
(Local anesthesia is considered to be a component of all fixed prosthodontic procedures.)

A. Fixed Partial Denture Pontics:

D6210	Pontic – Cast High Noble Metal	438	0	N
D6211	Pontic – Cast Base Metal	402	0	N
D6212	Pontic – Cast Noble Metal	427	0	N
D6240	Pontic – Porcelain Fused to High Noble Metal	441	0	N
D6241	Pontic – Porcelain Fused to Base Metal	406	0	N
D6242	Pontic – Porcelain Fused to Noble Metal	431	0	N
D6545	Cast Metal Retainer for Acid Etched Bridge	277	0	N

B. Fixed Partial Denture Retainers – Crowns:

D6750	Crown – Porcelain Fused to High Noble Metal	465	0	N
D6751	Crown – Porcelain Fused to Base Metal	423	0	N
D6752	Crown – Porcelain Fused to Noble Metal	448	0	N
D6790	Crown – Full Cast High Noble Metal	456	0	N
D6791	Crown – Full Cast Base Metal	418	0	N
D6792	Crown – Full Cast Noble Metal	446	0	N

► Fixed partial dentures are limited to 1 per tooth per 2 years.

C. Other Prosthodontic Services:

D6930	Recement Bridge	62	0	Y
D6970	Cast Post and Core in Addition to Fixed Partial Denture Retainer	180	0	N
D6972	Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	143	0	N
D6980	Bridge Repair, by report	129	1	N
D6985	Pediatric Partial Denture, fixed	413	1	N♣
D6999	Unspecified Fixed Prosthodontic Procedure, by report	**	1	N

♣ To prior authorize denture (s) submit a completed "Denture Prior Authorization Request Form" to The Office of Oral Health. A current "Denture Prior Authorization Request Form" is the last page of this fee schedule.

♣ When submitting for payment of prior authorized denture(s), use the start date (final impression date) as the date of service on the completed claim form. Do not submit the claim until the denture(s) are delivered.

♣ Reimbursement includes all necessary post delivery denture adjustments for 3 months.

♣ Regardless of the funding source, dentures are limited to 1 per arch per 5 years.

► When submitting for payment for cast bridges, use the start date (final impression date) as the date of service on the completed claim. Do not submit the claim until the cast bridge is delivered.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM
VIII.	**ORAL AND MAXILLOFACIAL SURGERY:** (Local anesthesia is considered to be a component of all oral and maxillofacial procedures.)			
A.	**Extractions:** Includes local anesthesia, suturing if needed, and routine post operative care.			
D7111	Extraction, Coronal Remnants – Deciduous Tooth Removal of soft tissue-retained coronal remnants.	64	0	Y
D7140	Extraction, Erupted tooth or Exposed Root (elevation and/or forceps removal) Includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary.	82	0	Y
B.	**Surgical Extractions:** Includes local anesthesia, suturing if needed, and routine post operative care.			
D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth. Includes cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.	122	0	Y
D7220	Removal of Soft Tissue Impaction Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation and bone removal.	135	0	Y
D7230	Removal of Partially Bone Impacted Tooth Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.	172	0	Y
D7240	Removal of Completely Bone Impacted Tooth Most of crown is covered by bone; requires mucoperiosteal flap elevation and bone removal.	209	0	Y
D7241	Removal of Completely Bone Impacted Tooth with unusual surgical complications. Most or all of the crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.	386	0	Y
D7250	Surgical Removal of Residual Tooth Roots (cutting procedure) Includes cutting of soft tissue and bone, removal of tooth structure, and closure.	124	0	Y
C.	**Other Surgical Procedures/Splints:**			
D7260	Oroantral Fistula Closure	458	0	Y♦
D7261	Primary Closure of a Sinus Perforation Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fistulous tract.	261	0	Y♦
D7270	Tooth Reimplantation and/or stabilization of accidentally evulsed or displaced tooth. Includes splinting and/or stabilization.	250	0	Y♦

♦ This procedure is not subject to the Adult Program $495 annual maximum benefit.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM
C:	**Other Surgical Procedures/Splints – continued:**			
D7280	Surgical Access of an Unerupted Tooth An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted.	197	0	N
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption To move/luxate teeth to eliminate ankylosis; not in conjunction with an extraction.	100	0	N
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth Placement of an orthodontic bracket, band or other device on an unerupted tooth, after its exposure, to aid in its eruption.	75	0	N
D7285	Biopsy of Oral Tissue – Hard (Bone, tooth)	155	0	Y♦
D7286	Biopsy of Oral Tissue – Soft	120	0	Y♦
D7310	Alveoloplasty in Conjunction with Extractions – per Quadrant	25	0	Y♦
D7311	Alveoloplasty in Conjunction with Extractions, 1-3 Teeth – per Quadrant	15	0	Y♦
D7320	Alveoloplasty **not** in Conjunction with Extractions – per Quadrant	150	0	Y♦
D7340	Vestibuloplasty – Ridge Extension Secondary Epithelialization	324	0	Y♦
D7350	Vestibuloplasty – Ridge Extension Including soft tissue grafts, muscle reattachments, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue.	324	0	Y♦
D7410	Excision of Benign Lesion Lesion diameter up to 1.25 cm	194	0	Y♦
D7411	Excision of Benign Lesion Lesion diameter greater than 1.25 cm	246	0	Y♦
D7412	Excision of Benign Lesion, Complicated Requires extensive undermining with advancement or rotational flap closure.	280	0	Y♦
D7413	Excision of Malignant Lesion Lesion diameter up to 1.25 cm	231	0	Y♦
D7414	Excision of Malignant Lesion Lesion diameter greater than 1.25 cm	360	0	Y♦
D7415	Excision of Malignant Lesion, Complicated Requires extensive undermining with advancement or rotational flap closure.	400	0	Y♦
D7440	Excision of Malignant Tumor – Intra-Osseous Lesion diameter up to 1.25 cm	222	0	Y♦
D7441	Excision of Malignant Tumor – Intra-Osseous Lesion diameter greater than 1.25 cm	347	0	Y♦
D7450	Removal of Odontogenic Cyst or Tumor Lesion diameter up to 1.25 cm	201	0	Y♦
D7451	Removal of Odontogenic Cyst or Tumor Lesion diameter greater than 1.25 cm	238	0	Y♦

♦ This procedure is not subject to the Adult Program $495 annual maximum benefit.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM
C:	**Other Surgical Procedures/Splints – continued:**			
D7460	Removal of Nonodontogenic Cyst or Tumor Lesion diameter up to 1.25 cm	197	0	Y♦
D7461	Removal of Nonodontogenic Cyst or Tumor Lesion diameter greater than 1.25 cm	282	0	Y♦
D7465	Destruction of lesion(s) by physical or chemical method	105	0	Y♦
D7471	Removal of Lateral Exostosis (maxilla or mandible)	200	0	Y♦
D7472	Removal of Torus Palatinus	200	0	Y♦
D7473	Removal of Torus Mandibularis	200	0	Y♦
D7485	Surgical Reduction Osseous Tuberosity	200	0	Y♦
D7510	Incision and Drainage of Abscess	82	0	Y♦

► When submitting for the incision and drainage of an abscess, indicate a corresponding tooth number on the completed claim form.

D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	261	0	Y♦
D7880	Occlusal Orthotic Appliance (TMJ Splint)	500	0	Y♦

► Occlusal orthotic appliances are limited to 1 appliance per patient per 2 years.

► Providers may use a CMS-1500 medical claim form or an ADA dental claim form when submitting for payment of an occlusal orthotic appliance.

D7910	Suture of Recent Small Wounds up to 5 cm	107	0	Y♦

► Note that suturing of recent small wounds excludes the closure of surgical incisions.

D7911	Complicated Suture – up to 5 cm Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure.	161	0	Y♦
D7912	Complicated Suture – greater than 5 cm Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure.	237	0	Y♦

► Note that complicated suturing involves reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure and excludes the closure of surgical incisions.

D7960	Frenulectomy (Frenectomy or Frenotomy)	150	0	N
D7971	Excision of Pericoronal Gingiva Surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth.	75	0	N
D7972	Surgical Reduction of Fibrous Tuberosity	150	0	Y♦
D.	**Miscellaneous Surgical Procedures:**			
D7999	Unspecified Surgical Procedure, by report	**	1	N

♦ This procedure is not subject to the Adult Program $495 annual maximum benefit.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM
IX.	**ORTHODONTICS:**			
A.	**Limited Orthodontic Treatment:**			
D8010	Limited Orthodontic Treatment of the Primary Dentition	655	1*	N
D8020	Limited Orthodontic Treatment of the Transitional Dentition	655	1*	N
D8030	Limited Orthodontic Treatment of the Adolescent Dentition	655	1*	N
D8040	Limited Orthodontic Treatment of the Adult Dentition	655	1*	N
B.	**Interceptive Orthodontic Treatment:**			
D8050	Interceptive Orthodontic Treatment of the Primary Dentition	940	1*	N
D8060	Interceptive Orthodontic Treatment of the Transitional Dentition	940	1*	N
C.	**Comprehensive Orthodontic Treatment:**			
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition	2905	1*	N
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition	2905	1*	N
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition	2925	1*	N
D.	**Treatment to Control Harmful Habits:**			
D8210	Removable Appliance Therapy	415	1*	N
D8220	Fixed Appliance Therapy	415	1*	N
E.	**Other Orthodontic Services:**			
D8692	Replacement of Lost or Broken Retainer	134	0	N
► Replacement retainers are limited to 1 per patient per arch per lifetime.				
D8999	Unspecified Orthodontic Procedure, by report	**	1	N

* To qualify for orthodontic treatment a patient's malocclusion must be severe enough to satisfy specific diagnostic criteria. For detailed instructions, including necessary paperwork, contact The Office of Oral Health..

Definitions:

Primary (Deciduous) Dentition: Teeth developed and erupted first in order of time.

Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.

Adult (Permanent) Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

► Reimbursement for orthodontic treatment includes all necessary maintenance to and replacement of brackets and wires.

► When submitting for payment of prior authorized orthodontic appliances, please place a "U" to indicate upper and an "L" to indicate lower in the "surface" section of the claim form.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM
X.	**ADJUNCTIVE GENERAL SERVICES:**			
A.	**Unclassified Treatment:**			
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedures	45	0	Y♦
B.	**Anesthesia:**			
D9220	General Anesthesia – First 30 Minutes	175	0	Y
D9221	General Anesthesia – Each Additional 15 Minutes	63	0	Y
D9230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide	57	0	Y
D9241	Intravenous Sedation/Analgesia – First 30 Minutes	161	0	Y
D9242	Intravenous Sedation/Analgesia – Each Additional 15 Minutes	65	0	Y
D9248	Non-Intravenous Conscious Sedation Oral conscious sedation with central nervous system depressants which causes a moderately depressed level of consciousness. This does **not** include written prescriptions, mild sedatives and/or nitrous oxide sedation.	125	0	Y
C.	**Professional Visits:**			
D9420	Hospital Call	100	0	Y
D.	**Patient Management:**			
D9920	Behavior Management	47	0	Y

► Behavior management cannot be billed when one of the above methods of anesthesia is billed on the same date of service.

E.	**Occlusal Therapy:**			
D9940	Occlusal Guard: A removable dental appliance which is designed to minimize the effects of bruxism and other occlusal factors.	218	0	Y

► Occlusal guards are limited to 1 per patient per 2 years.

D9941	Fabrication of Athletic Mouthguard	66	0	N

► Athletic mouthguards are limited to 1 per patient per 2 years.

D9950	Occlusal Analysis – Mounted Case	120	0	N
D9951	Occlusal Adjustment – Limited	67	0	N
D9952	Occlusal Adjustment – Complete	238	0	N

♦ This procedure is not subject to the Adult Program $495 annual maximum benefit.

CODE	DESCRIPTION	FEE	A	ADULT PROGRAM
F.	**Miscellaneous Services:**			
D9973	External Bleaching – Per Tooth	116	0	N
D9974	Internal Bleaching – Per Tooth	116	0	N
G.	**Unspecified Care:**			
D9999	Unspecified Adjunctive Procedure, by report	**	1	N
H.	**Interpreter Services:**			
T1013	Interpreter Services – 15 minutes	15	0	Y♦

► Interpreter services must be submitted on a CMS-1500 medical claim form.

► Indicate the number of 15 minute increments (units) in section 24G of the CMS-1500 claim form.

♦ This procedure is not subject to the Adult Program $495 annual maximum benefit.

Denture Prior Authorization Request Form
(Effective 01/01/2008)

A. Patient Information:

Name: _____
Date of Birth: _____Age: _____
Patient Address: _____
Patient Medicaid I.D. Number: _____
Restorative Treatment Completed to Date (circle one - N/A only if edentulous): **Yes No N/A**
Oral Hygiene (circle one - N/A only if edentulous): **Good Fair Poor N/A**

B. Denture Information: (Please answer **ALL** questions)

1. Is patient edentulous on maxillary arch?
   __ yes. If yes, estimated number of years edentulous: _____
   __ no. If no, please indicate all remaining maxillary teeth by number: _____
2. Is patient edentulous on mandibular arch?
   __ yes. If yes, estimated number of years edentulous: _____
   __ no. If no, please indicate all remaining mandibular teeth by number: _____
3. Existing denture(s)? ___ yes - go to #4
   ___ no - go to #5
4. Please provide a brief description of the existing denture(s):
   Upper denture: ___ yes…….type: _____
   approximate age of denture: _____
   condition of denture: _____
   frequency of use: _____
   ___ no
   Lower denture: ___ yes…….type: _____
   approximate age of denture: _____
   condition of denture: _____
   frequency of use: _____
   ___ no
5. Do you expect the patient to tolerate and successfully adjust to the proposed treatment?
   ___ yes ___ no
6. Based on the patient's denture history, do you expect the patient to wear the proposed denture (s) on a regular basis? ___ yes ___ no ___ n/a

C. Medical Information:

Medical Condition(s) making the requested denture(s) a medical necessity: _____
_____

D. Additional Information:

_____

E. Proposed Treatment:

Complete Denture:	___Maxillary (#D5110)	___Mandibular (#D5120)
Immediate Denture:	___Maxillary (#D5130)	___Mandibular (#D5140)
Resin-Based Partial:	___Maxillary (#D5211)	___Mandibular (#D5212)
Cast Partial Denture:	___Maxillary (#D5213)	___Mandibular (#D5214)
Overdenture:	___Maxillary (#D5860)	___Mandibular (#D5860)
Laboratory Reline:	___Maxillary (#D5750)	___Mandibular (#D5751)
Laboratory Rebase:	___Maxillary (#D5710)	___Mandibular (#D5711)
Pediatric Partial, fixed	___Maxillary (#D6985)	___Mandibular (#D6985)

F. Requesting Provider Information-:

Provider Name: _____
Medicaid Individual and Group Provider Number(s): _____

Provider signature:_____
Date Submitted:_____

Dental Services Prior Authorization Request Form

(Effective 01/01/2008)

(Please Print or Type)

1. Patient Information:

Patient Name:_____

Date of Birth_____ Age:_____

Patient I.D. Number:_____

2. Treatment Request:

Procedure Code(s):_____

Procedure Code Description:_____

Reason for Request:

_____

_____

_____

Treatment Rendered? ☐ No. ☐ Yes. If yes, Date of Service:_____

3. Attachments:

☐ None.

☐ ADA Claim Form.

☐ Radiograph(s). Specify type:_____

☐ Periodontal Charting.

☐ Other. Specify:_____

4. Provider Information:

Provider Name / Practice Name:_____

Medicaid Individual and Group Provider Number(s):_____

Provider Signature:_____

Date Submitted_____